VERMONT

AGENCY OF HUMAN SERVICES

DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection
103 South Main Street
Waterbury, VT 05671-2306
http://www.dail.vermont.gov
Voice/TTY (802) 871-3317
To Report Adult Abuse: (800) 564-1612
Fax (802) 871-3318

February 18, 2015

Ms. Lois Langlois, Administrator
Rivers Edge Community Care Home
5 Hunt Street
Bennington, VT 05201

Dear Ms. Langlois:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **January 21, 2015.** Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M. Cota, RN
Licensing Chief

PC:jl

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0085	A. BUILDING: _____ B. WING _____	01/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERS EDGE COMMUNITY CARE HOME	5 HUNT STREET BENNINGTON, VT 05201

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R100	Initial Comments: An unannounced on-site re-licensing survey was conducted on 1/20 and 1/21/2015, by the Division of Licensing and Protection. There were regulatory findings regarding the survey.	R100	RATES FOR RESIDENT #1 WERE NOT COMPLETED DIT PENDING APPROVAL FOR MEDICAID CFC PROGRAM. RATES WILL BE WRITTEN ON ADMISSION AGREEMENT BY EITHER RN / OWNER AT TIME OF ADMISSION. RESIDENTS / FAMILIES WILL BE GIVEN PRIVATE ROOM RATES UNTIL MEDICAID CFC APPROVAL. CHANGES WILL BE MADE BY OWNER WHEN CFC RATES / PATIENT SHARE RATES DETERMINED. CHANGES WILL BE MADE IMMEDIATELY. ALL ADMISSION AGREEMENTS ARE UP TO DATE.	
R104 SS=C	V. RESIDENT CARE AND HOME SERVICES 5.1 Admission 5.2.a Prior to or at the time of admission, each resident, and the resident's legal representative if any, shall be provided with a written admission agreement which describes the daily, weekly, or monthly rate to be charged, a description of the services that are covered in the rate, and all other applicable financial issues, including an explanation of the home's policy regarding discharge or transfer when a resident's financial status changes from privately paying to paying with SSI or ACCS benefits. This admission agreement shall specify at least how the following services will be provided, and what additional charges there will be, if any: all personal care services; nursing services; medication management; laundry; transportation; toiletries; and any additional services provided under ACCS or a Medicaid Waiver program. If applicable, the agreement must specify the amount and purpose of any deposit. This agreement must also specify the resident's transfer and discharge rights, including provisions for refunds, and must include a description of the home's personal needs allowance policy. (1) In addition to general resident agreement requirements, agreements for all ACCS participants shall include: the ACCS services, the specific room and board rate,	R104		

Division of Licensing and Protection
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Administrator — 2-17-15

T104-T999 POC accepted 2/17/15 BD[illegible]

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0085	A. BUILDING: _____ B. WING _____	01/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERS EDGE COMMUNITY CARE HOME	5 HUNT STREET BENNINGTON, VT 05201

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R104	Continued From page 1 the amount of personal needs allowance and the provider's agreement to accept room and board and Medicaid as sole payment. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to insure that 4 out of 6 residents, Resident # 1, 3, 5 and 6, had signed admission agreements which describes the daily, weekly, or monthly rate to be charged. Findings include: On 1/20/2015 at 1:30 PM during review of medical records looking specifically for signed admission agreements and the content of the agreement, it was found that Residents #1, 3, 5 and 6 did not have any rates listed that would be charged for their stay in the facility. The Registered Nurse confirmed at this time that there was no evidence of rates being listed and further stated that the rates may have changed as some of the admission agreements were completed years ago. Per interview with the owner at 1:30 PM on 1/20/2015, the rates had not yet been set and it is not the facilities procedure to put a rate in if there is none yet set.	R104		
R145 SS=F	V. RESIDENT CARE AND HOME SERVICES 5.9.c (2) Oversee development of a written plan of care for each resident that is based on abilities and needs as identified in the resident assessment. A plan of care must describe the care and services necessary to assist the resident to maintain independence and well-being;	R145		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0085	A. BUILDING: _____ B. WING _____	01/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERS EDGE COMMUNITY CARE HOME	5 HUNT STREET BENNINGTON, VT 05201

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R145	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to develop a written care plan for 6 of 6 residents reviewed, Resident #1, 2, 3, 4, 5 and 6, that is based on abilities and needs as identified in the resident assessment. A plan of care must describe the care and services necessary to assist the resident to maintain independence and well-being. Findings include: On 1/21/2015, review of Resident # 1 presented with no evidence of a written care plan to describe the residents needs, problems, goals and interventions. Upon further review of the other residents in the sample, #2, 3, 4, 5 and 6, there was no evidence of a written care plan. Per interview with the Registered Nurse (RN) at 12:05 PM on 1/21/2015, s/he confirmed that what the facility was using as a care plan, did not reflect the requirements that identify the needs and abilities based on the resident assessment.	R145	ATTACHED IS A SAMPLE OF CARE PLAN WHICH ALL RESIDENTS #1-6 HAD COMPLETED. AND UP TO DATE. A REVISED CARE PLAN WILL BE CREATED TO REFLECT RESIDENTS NEEDS + ABILITIES WITH ADL'S AND IADL'S. ALL CARE PLANS WILL BE REVISED BY APRIL 1ST 2015	
R155 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.9.c. (12) Assume responsibility for staff performance in the administration of or assistance with resident medication in accordance with the home's policies. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, the facility and registered nurse failed to ensure acceptable staff performance in	R155		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0085	A. BUILDING: _____ B. WING _____	01/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERS EDGE COMMUNITY CARE HOME	5 HUNT STREET BENNINGTON, VT 05201

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R155	Continued From page 3 administration of medications. Findings include: During observation of medication administration at 1:55 PM on 1/20/2015, an error occurred in which Resident #7 received Tylenol 500mg tablets (two) instead of the ordered Tylenol 325mg (two) to be given as needed. Per interview with medication delegated caregiver, after the administration of the medication, s/he stated that the resident had not asked for medication for discomfort and that Resident #7 did not appear to be uncomfortable at the time of the administration of the Tylenol. S/he further stated that s/he administered the 1000mg of Tylenol from the standing orders. Per interview with the Registered Nurse (RN) at 2:45 PM, s/he stated that the Tylenol 1000mg should not have been administered from the standing orders, as the standing orders are for as needed (prn) usage. The RN stated that s/he does not routinely monitor the staff during a medication observation. The RN further stated that there are no specific policies for medication administration.	R155	WRITTEN POLICIES FOR THE HOME'S MEDICATION MANAGEMENT TO INCLUDE MEDICATION OBSERVATION WILL BE COMPLETED BY 4-1-15 POLICIES WILL INCLUDE FACILITY PRACTICES FOR RESIDENTIAL CARE SETTING. POLICIES WILL BE LOOKED PART OF ADMISSION PROCESS TO REVIEW WITH RESIDENTS + FAMILIES. ROUTINE MEDICATION OBSERVATION WILL BE COMPLETED + PERFORMED BY RN 3-1-15	
R160 SS=F	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.a Each residential care home must have written policies and procedures describing the home's medication management practices. The policies must cover at least the following: (1) Level III homes must provide medication management under the supervision of a licensed nurse. Level IV homes must determine whether the home is capable of and willing to provide assistance with medications and/or administration	R160		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0085	A. BUILDING: _____ B. WING _____	01/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERS EDGE COMMUNITY CARE HOME	5 HUNT STREET BENNINGTON, VT 05201

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R160	Continued From page 4 of medications as provided under these regulations. Residents must be fully informed of the home's policy prior to admission. (2) Who provides the professional nursing delegation if the home administers medications to residents unable to self-administer and how the process of delegation is to be carried out in the home. (3) Qualifications of the staff who will be managing medications or administering medications and the home's process for nursing supervision of the staff. (4) How medications shall be obtained for residents including choices of pharmacies. (5) Procedures for documentation of medication administration. (6) Procedures for disposing of outdated or unused medication, including designation of a person or persons with responsibility for disposal. (7) Procedures for monitoring side effects of psychoactive medications. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility does not have written policies and procedures describing the home's medication management practices. Findings include: On 1/21/2015, at 3:00 PM, during record reviews of policies, the Registered Nurse (RN) was asked to provide the surveyor with evidence of written policies and procedures for medication management. Per interview with the RN on 1/20/2015 at 3:10 PM, s/he stated that there are no specific policies for medication administration. Per review of the policy book, there are policies from BAYADA nursing services, but they are not specific to the facility practices. The RN stated that when s/he came to the facility there were no	R160		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0085	A. BUILDING: _____ B. WING _____	01/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERS EDGE COMMUNITY CARE HOME	5 HUNT STREET BENNINGTON, VT 05201

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R160	Continued From page 5 policies and s/he implemented usage of the policies from his/her previous employer and did not adapt them for the Residential Care setting	R160		
R168 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.d If a resident requires medication administration, unlicensed staff may administer medications under the following conditions: (6) Insulin. Staff other than a nurse may administer insulin injections only when: i. The diabetic resident's condition and medication regimen is considered stable by the registered nurse who is responsible for delegating the administration; and ii. The designated staff to administer insulin to the resident have received additional training in the administration of insulin, including return demonstration, and the registered nurse has deemed them competent and documented that assessment; and iii. The registered nurse monitors the resident's condition regularly and is available when changes in condition or medication might occur. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to insure that designated staff that is to administer insulin to the residents, have received additional training in the administration of insulin, including return demonstration, nor has	R168	/INSULIN ADMINISTRATION + DIABETIC EDUCATION INSTRUCTED TO ALL STAFF DURING DELEGATION PROCESS. DELEGATED STAFF ARE REQUIRED TO DEMONSTRATE INSULIN ADMINISTRATION COMPETENCY, INCLUDING BS TESTING. DM / INSULIN INSERVICE TO BE SCHEDULED BEFORE MARCH 30TH. DOCUMENTATION OF TRAINING WILL BE COMPLETED AT LEAST YEARLY.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0085	A. BUILDING: _____ B. WING _____	01/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERS EDGE COMMUNITY CARE HOME	5 HUNT STREET BENNINGTON, VT 05201

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R168	Continued From page 6 the registered nurse has deemed them competent and documented that assessment. Findings include: On 1/20/2015 at 1:10 PM, during review of Resident #3, the orders are to administer Novolog insulin 3 Units with meals and Lantus insulin 20 Units in the evening. The resident has dial dose pens for the insulin administration and per the Registered Nurse (RN), s/he is unable to self administer the insulin and staff needs to inject. The RN stated that s/he has not provided in-service training on medication administration since 2013. S/he also, when requested to provide evidence of training for medication delegated staff that they were competent and had done return demonstration, s/he stated that it is not documented and there is no evidence that it has been done.	R168		
R174 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.h. (2) Medications requiring refrigeration shall be stored in a separate, locked container impervious to water and air if kept in the same refrigerator used for storage of food. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to properly store medications requiring refrigeration in a separate, locked container. Findings include:	R174	ALL MEDICATIONS REQUIRING REFRIGERATION WILL BE KEPT IN A SEPERATE LOCKED CONTAINER. INSULIN HAS BEEN REMOVED FROM MAIN FRIDGE AND PLACE IN APPROPRIATE CONTAINER HOSPICE MEDS WILL ALSO BE PLACED IN LOCKED CONTAINER. ALL STAFF INFORMED OF CHANGES AND WILL COMPLY WITH STORING MEDS IN NEW CONTAINER.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0085	A. BUILDING: _____ B. WING _____	01/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERS EDGE COMMUNITY CARE HOME	5 HUNT STREET BENNINGTON, VT 05201

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R174	Continued From page 7 During the initial tour of the facility on 1/20/2015 at 10:30 AM, there were Dulcolax and Glycerine suppositories as well as Hospice medications in a cardboard emergency Hospice Kit that consisted of medications to only be utilized for a resident on Hospice, on the door shelves in a storage refrigerator in the basement. There was insulin, Lantus and Novolog, found on the door shelf of the main refrigerator in the main kitchen. The Registered Nurse, at the time of discovery, confirmed that the medications were not in separate, locked containers in the refrigerators. S/he stated that they were unaware of the need for a separate locked container being needed.	R174		
R179 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.11 Staff Services 5.11.b The home must ensure that staff demonstrate competency in the skills and techniques they are expected to perform before providing any direct care to residents. There shall be at least twelve (12) hours of training each year for each staff person providing direct care to residents. The training must include, but is not limited to, the following: (1) Resident rights; (2) Fire safety and emergency evacuation; (3) Resident emergency response procedures, such as the Heimlich maneuver, accidents, police or ambulance contact and first aid; (4) Policies and procedures regarding mandatory reports of abuse, neglect and exploitation; (5) Respectful and effective interaction with residents; (6) Infection control measures, including but not	R179	STAFF INSERVICES SCHEDULED MONTHLY FOR REQUIRED 12°/YR TRAININGS. FOLLOW-UP INSERVICED TRAININGS WILL BE COMPLETED BY/ RN FOR STAFF UNABLE TO ATTEND @ SCHEDULED TIME. WITHIN 1WK. ALL STAFF WILL COMPLETE 12 HOURS TRAINING TO INCLUDE 7 MANDATORY REQUIRED BY STATE.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0085	A. BUILDING _____ B. WING _____	01/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERS EDGE COMMUNITY CARE HOME	5 HUNT STREET BENNINGTON, VT 05201

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R179	Continued From page 8 limited to, handwashing, handling of linens, maintaining clean environments, blood borne pathogens and universal precautions; and (7) General supervision and care of residents. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to insure staff demonstrate competency in the skills and techniques they are expected to perform before providing any direct care to residents for 2 of 5 employees. Findings include.: On 1/20/2015 during record review at 11:45 AM, it was found that 2 employees, one hired 8/29/2014 and the other re-hired 11/17/2014, had no evidence that the regulated training had been provided. At 12:00 PM, the Registered Nurse confirmed that there is no orientation training upon hire and that the 2 employees have no evidence of training in the mandatory required fields since being employed. S/he also confirmed at this time that the required 12 hours of training had not been achieved for these 2 employees.	R179		
R181 SS=F	V. RESIDENT CARE AND HOME SERVICES 5.11 Staff Services 5.11.d The licensee shall not have on staff a person who has had a charge of abuse, neglect or exploitation substantiated against him or her, as defined in 33 V.S.A. Chapters 49 and 69, or one who has been convicted of an offense for actions related to bodily injury, theft or misuse of funds or property, or other crimes inimical to the	R181		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0085	A. BUILDING: _____ B. WING _____	01/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERS EDGE COMMUNITY CARE HOME	5 HUNT STREET BENNINGTON, VT 05201

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R181	Continued From page 9 public welfare, in any jurisdiction whether within or outside of the State of Vermont. This provision shall apply to the manager of the home as well, regardless of whether the manager is the licensee or not. The licensee shall take all reasonable steps to comply with this requirement, including, but not limited to, obtaining and checking personal and work references and contacting the Division of Licensing and Protection in accordance with 33 V.S.A. §6911 to see if prospective employees are on the abuse registry or have a record of convictions. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the facility failed to comply with regulations that require contacting the Division of Licensing and Protection in accordance with 33 V.S.A. §6911 to see if prospective employees are on the abuse registry and failed to contact the VCIC to obtain a record of convictions for 5 of the 5 employees in the survey review sample. Findings include: 1. On 1/20/15, the review of 5 employee records for current licensure, if required, Vermont Criminal Background Check (VCIC), Adult and Child Abuse Registries, presented that the facility failed to obtain a VCIC background check for 1 of the 5 employees. Per interview with the Registered Nurse (RN) at 1:10 PM on 1/20/2015, the VCIC check was not done because the employee was recently rehired and the original VCIC did not produce findings of criminal offenses. S/he stated that the employee had been absent from the facility for greater than 6 months before returning and was not aware of the need to have the VCIC check done again. 2. On 1/20/2015, review of 5 employee records	R181	BACKGROUND CHECKS WILL BE COMPLETED DURING HIRING PROCESS TO INCLUDE VCIC, ADULT + CHILD ABUSE REGISTRIES. BACKGROUND CHECKS WILL BE COMPLETED PRIOR EMPLOYEES 1ST SCHEDULED SHIFT. OWNER WILL ENSURE THIS IS COMPLETED	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0085	A. BUILDING: _____ B. WING _____	01/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERS EDGE COMMUNITY CARE HOME	5 HUNT STREET BENNINGTON, VT 05201

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R181	Continued From page 10 presented that no Adult Abuse Registry checks were done for 4 of the 5 and there was no evidence of Child Registry checks being performed on any of the 5 reviewed. The RN confirmed at 1:10 PM on 1/20/2015, that there was no evidence of the background checks being conducted as per required.	R181		
R230 SS=C	VI. RESIDENTS' RIGHTS 6.18 The enumeration of residents' rights shall not be construed to limit, modify, abridge or reduce in any way any rights that a resident otherwise enjoys as a human being or citizen. A summary of the obligations of the residential care home to its residents shall be written in clear language, large print, given to residents on admission, and posted conspicuously in a public place in the home. Such notice shall also summarize the home's grievance procedure and directions for contacting the Ombudsman Program and Vermont Protection and Advocacy, Inc. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to have a summary of the obligations of the residential care home to its residents that is written in clear language, large print, posted conspicuously in a public place in the home. Such notice shall also summarize the home's grievance procedure and directions for contacting the Ombudsman Program and Vermont Protection and Advocacy, Inc. Findings include: During the initial tour on 1/20/2015 at 9:45 AM there was no evidence of the posting of	R230	RESIDENTS RIGHTS POSTER MOVED TO PUBLIC AREA FOR RESIDENTS / VISITORS TO VIEW. DIRECTIONS FOR CONTACTING OMBUDSMAN + VT PROTECTION + ADVOCACY WILL BE CLEARLY DISPLAYED. HOUSE RULES WILL BE POSTED FOR ALL RESIDENTS TO VIEW. ALL WILL BE COMPLETED BY 2-11-15	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0085	A. BUILDING: _____ B. WING _____	01/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERS EDGE COMMUNITY CARE HOME	5 HUNT STREET BENNINGTON, VT 05201

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R230	Continued From page 11 obligations to the residents, no evidence of postings of house rules and the residents rights were not in a conspicuous public location to be readily accessible to all residents and the public. Also there was no evidence of the posting for the grievance procedure. This was confirmed by the Registered Nurse at the time of discovery.	R230		
R235 SS=C	VII. NUTRITION AND FOOD SERVICES 7.1.a.(4) The home must follow the written, posted menus. If a substitution must be made, the substitution shall be recorded on the written menu. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews and record review, the facility failed to follow the written, posted menus and to record substitutions on the written menu. Findings include: At 11:00 AM, during initial tour of the facility on 1/20/2015 it was noted that there was a large dry erase board that listed the breakfast choices and the weekly choices for lunch. At 11:15 AM on 1/20/2015, per interview with the caregiver that was assisting with meal preparation and prepping for serving, that if a substitution is desired, they just give it, but don't write it down. S/he further stated that they don't always follow the menu that is listed and this was confirmed by a second caregiver that stated on Sunday, January 18, 2015, the menu indicated to serve turkey sandwiches, but chicken salad was prepared and served instead. The caregivers indicated that they prepare and serve what they are directed to	R235		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0085	A. BUILDING: _____ B. WING _____	01/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERS EDGE COMMUNITY CARE HOME	5 HUNT STREET BENNINGTON, VT 05201

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R235	Continued From page 12 serve and if not told what to serve, they do not follow the menu, but make whatever they find. At 11:30 AM, the Registered Nurse (RN) indicated that the dinner for January 20, 2015 was to be Kielbasa, cabbage and potato, and this was confirmed by the owner. The menu posted for 1/20/2015 indicated that dinner was to be corn dogs, roasted potatoes, yellow beans and Swiss cake. Per review of the menu on 1/21/2015 at 10:30 AM, there was no indication that the substitution had been made on the menu. The RN stated that the substitutions do not get written on the menu and confirmed at this time the posted menu had not been followed.	R235		
R236 SS=C	VII. NUTRITION AND FOOD SERVICES 7.1.a. (5) The home shall keep menus, including any substitutions, for the previous month on file and available for examination by the licensing agency. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to keep menus, including any substitutions, for the previous month on file and available for examination by the licensing agency. Findings include: Upon request on 1/20/2015 at 11:30 AM, for menus for the past month to review, the Registered Nurse stated that the menus are not kept from month to month.	R236	WRITTEN MENUS WILL BE KEPT FOR AT LEAST 1 MONTH WITH CHANGES MADE ON THEM. DAILY MENU IS WRITTEN ON DRY ERASE BOARD IN LARGE PRINT FOR RESIDENTS TO VIEW IN DINING ROOM. DAY STAFF WILL BE RESPONSIBLE TO KEEP MENUS UPDATED + MAINTAIN DAILY BOARD. OWNER WILL ENSURE THIS IS DONE DAILY.	
R247 SS=F	VII. NUTRITION AND FOOD SERVICES	R247		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0085	A. BUILDING: _____ B. WING _____	01/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERS EDGE COMMUNITY CARE HOME	5 HUNT STREET BENNINGTON, VT 05201

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R247	Continued From page 13 7.2 Food Safety and Sanitation 7.2.b All perishable food and drink shall be labeled, dated and held at proper temperatures: (1) At or below 40 degrees Fahrenheit. (2) At or above 140 degrees Fahrenheit when served or heated prior to service. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to provide evidence that all perishable food and drink are held at proper temperatures: (1) At or below 40 degrees Fahrenheit. (2) At or above 140 degrees Fahrenheit when served or heated prior to service. Findings include: 1. Upon initial tour of facility on 1/20/2015 at 10:30 AM, it was observed that the ice cream, cool whip and concentrated frozen juice cans located in a freezer in the basement of the facility were soft and easy to squeeze, indicating thawing. This was confirmed by the accompanying Registered Nurse (RN). Request of temperature logs for the freezer and refrigerators resulted in the RN stating they had not been completed. 2. On 1/20/2015 at 10:30 AM, request for temperature logs for heated and served foods resulted in the RN stating that s/he knew they are checked, but that they are not recorded. Interview with the owner/manager at 11:00 AM confirmed that s/he takes the temperatures of meats that have been cooked but does not write them down and has no evidence to indicate the temperatures have been taken.	R247	TEMP LOGS TO BE COMPLETED BY STAFF DAILY AND MONITORED BY OWNER. TEMP OF FRIDGE/FREEZER NOT AT APPROPRIATE TEMP RANGE WILL BE REPORTED TO OWNER. TEMP OF COOKED MEATS WILL BE TAKEN BY OWNER + WRITTEN ON LOG EACH TIME. LOG WILL BE KEPT IN KITCHEN FOR OWNER TO MAINTAIN 2-11-15	

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0085	A. BUILDING: _____ B. WING _____	01/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERS EDGE COMMUNITY CARE HOME	5 HUNT STREET BENNINGTON, VT 05201

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R302	Continued From page 14	R302		
R302 SS=F	IX. PHYSICAL PLANT 9.11 Disaster and Emergency Preparedness 9.11.c Each home shall have in effect, and available to staff and residents, written copies of a plan for the protection of all persons in the event of fire and for the evacuation of the building when necessary. All staff shall be instructed periodically and kept informed of their duties under the plan. Fire drills shall be conducted on at least a quarterly basis and shall rotate times of day among morning, afternoon, evening, and night. The date and time of each drill and the names of participating staff members shall be documented. This REQUIREMENT is not met as evidenced by: Based on resident and staff interview and record review, fire drills have not been conducted at rotated times to include the morning and night shift. Findings include: 1. On 1/20/2015 at 1:00 PM, per review of the log regarding Fire drills, they were conducted at the facility in January, February, March, April, July and August 2014. Per review of the fire drill log the fire drills were conducted 4 times between the hours of 1:00 PM and 2:00 PM and twice in the evenings around 5:00 PM. Per confirmation by the Registered Nurse on 1/20/2015 at 1:10 PM, the fire drills had not been conducted as per regulation on the night shift and in the mornings. S/he further stated that the quarterly fire drill was missed in December because of the holidays. 2. During interviews with Resident # 4, 6 and 7	R302	FIRE DRILLS WILL BE CONDUCTED AT LEAST QUARTERLY ON ALL SHIFTS WITH ROTATING TIMES BETWEEN DAYS, EVENINGS, NIGHTS. EACH DRILL WILL INCLUDE DATE/TIME/STAFF WHO PARTICIPATED IN DRILL. FIRE DRILLS WILL BE SUPERVISED BY RN OR OWNER. FIRE DRILL DOCUMENTATION WILL BE MAINTAINED BY RN/OWNER. 2/11/15	

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0085	A. BUILDING: _____ B. WING _____	01/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERS EDGE COMMUNITY CARE HOME	5 HUNT STREET BENNINGTON, VT 05201

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R302	Continued From page 15 on 1/21/2015, they were not aware of any fire drills being conducted during the night or in the mornings before lunch.	R302		
R999 SS=A	MISCELLANEOUS Based on observation and staff interview, the facility failed to adhere to regulation 4.14f. The home shall make written reports resulting from inspections readily available to residents and to the public in a place readily accessible to residents where individuals wishing to examine the results do not have to ask to see them. The home must post a notice of the availability of such written reports. Findings include: During the initial tour of the facility on 1/20/2015 at 9:45 AM, there was no evidence of the most recent results of inspection and no posting of availability of the written reports. Confirmed by the Registered Nurse at this time that the survey results were not posted. S/he stated that they are probably in the filing cabinet.	R999	WRITTEN REPORTS WILL BE POSTED IN PUBLIC PLACE FOR VIEWING WITH COMPUTER FROM 1/21/15 INSPECTION PREVIOUS SURVEY RESULTS WERE IN FILING CABINET BUT NOT VISIBLE TO PUBLIC OWNER WILL ENSURE COMPLETED SURVEY POSTED UPON RECEIVING.	